**Definition**: Acute appendicitis is the inflammation of the vermiform appendix; a blind ended tube connected to the cecum of the bowel. Although the cause is unknown, most theories relate to an obstruction of the appendical lumen which prevents the escape of secretions and eventually leads to a rise in intra-luminal pressure with the appendix. The increased pressure can lead to mucosal ischemia with stasis, providing an environment for bacterial overgrowth. The obstruction may be caused by: fecolith, parasites, calculi, foreign body, neoplasm, stricture of worms, lymphoid hyperplasia secondary to Crohn’s disease, carcinoid syndrome or viral illnesses including upper respiratory infection, mononucleosis, and gastroenteritis. (1,2)

**Incidence**: Acute appendicitis is the most common abdominal condition requiring surgery in children, accounting for more than 320,000 operations in the United States annually. Appendicitis accounts for 1/3 of all childhood admissions for abdominal pain. The incidence of perforated appendix is highest in infants, 70-95% of children <1 year, 70-90% of children 1-4 years, and 10-20% of adolescents with acute appendicitis have a perforated appendix. The reported median perforation rate in children is 38.7%. (1-5)

**Diagnosis**: The diagnosis of acute appendicitis must be considered in children who present with abdominal pain. It is most common in 4- to 15-year-olds. (4,5)

**Inclusion Criteria** (1,4)
- Children ≥2 years presenting with abdominal pain and signs/symptoms highly suspicious of acute appendicitis

**Exclusion Criteria** (1-4)
- Children <2 years
- Previous appendectomy
- History of bloody stools
- Crohn’s disease
- History of cystic fibrosis, transplant or malignancy

**Diagnostic Evaluation** (3,5-7)
Children with appendicitis have a risk of progressing to septic shock. Clinicians should immediately refer to the Septic Shock guideline and intervene rapidly if patient has toxic-appearance, ill-appearance, altered mental status, and/or compromised perfusion with abnormal vital signs.

**Vital Sign Changes of Sepsis** (8)

<table>
<thead>
<tr>
<th>Age</th>
<th>Heart Rate</th>
<th>Resp Rate</th>
<th>Systolic BP</th>
<th>Temp (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0d - 1m</td>
<td>&gt;205</td>
<td>&gt;60</td>
<td>&lt;60</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;1m - 3m</td>
<td>&gt;205</td>
<td>&gt;60</td>
<td>&lt;70</td>
<td>&lt;36 or &gt;38</td>
</tr>
<tr>
<td>&gt;3m - 1y</td>
<td>&gt;190</td>
<td>&gt;60</td>
<td>&lt;70</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;1y - 2y</td>
<td>&gt;190</td>
<td>&gt;40</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;2y - 4y</td>
<td>&gt;140</td>
<td>&gt;40</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;4y - 6y</td>
<td>&gt;140</td>
<td>&gt;34</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;6y - 10y</td>
<td>&gt;140</td>
<td>&gt;30</td>
<td>&lt;70 + (age in yr x 2)</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;10y - 13y</td>
<td>&gt;100</td>
<td>&gt;30</td>
<td>&lt;90</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
<tr>
<td>&gt;13y</td>
<td>&gt;100</td>
<td>&gt;20</td>
<td>&lt;90</td>
<td>&lt;36 or &gt;38.5</td>
</tr>
</tbody>
</table>

**Signs and Symptoms of Shock** (8)

<table>
<thead>
<tr>
<th>Exam Abnormalities</th>
<th>Cold Shock</th>
<th>Warm Shock</th>
<th>Non-Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral Pulses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capillary refill</td>
<td>≥3 sec</td>
<td>Flash (&lt;1 sec)</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Mottled, cool</td>
<td>Flushed, ruddy, erythroderma (other than face)</td>
<td>Petechiae below the nipple, any purpura</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Decreased, irritability, confusion, inappropriate crying or drowsiness, poor interaction with parents, lethargy, diminished arousability, obtund</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical history and physical (H&P) alone is sufficient for diagnosis when the index of suspicion for appendicitis is high or low. (5,9)

**History: Assess for**
- Pain in the abdomen that is continuous even when lying down, first around the umbilicus, then moving to the lower right abdomen (McBurney’s Point)
- Pain may also be in the right upper quadrant (RUQ) under the gallbladder, in the pelvis, across the top of the bladder, and behind the large intestine, depending on the position of the appendix
- Pain intensifies with activity, deep breathing, coughing, and sneezing
- Nausea, loss of appetite, lack of interest in favorite food, vomiting
- Frequent, small volume stool or mucous (tenesmus)
- Fever, essentially always following onset of other symptoms
- Abdominal swelling
- Menstrual and sexual history

**Physical Examination: Assess for** (6,7)
- A quiet child reluctant to move, sometimes with hips flexed
- Child reluctant to stand erect, walk, or make sudden movements
- Tenderness in the right lower quadrant (RLQ) of the abdomen (examine last)
- Peritoneal signs

**Classic Signs and Symptoms for High Index of Suspicion Cases** (8)
- Nausea, anorexia (less reliable in young children)
- Point of maximal tenderness in RLQ
- Vomiting after onset of pain
- Progressive increase in pain
- Migration of pain to RLQ after onset in mid abdomen (usually periumbilical)
**Classic Signs and Symptoms for Low Index of Suspicion Cases:** (3)
- Absence of nausea, emesis or anorexia
- Minimal or absent abdominal tenderness without localization in RLQ
- Normal WBC and differential
- Pain that is intermittent or cramping in nature

**Pediatric Appendicitis Score (PAS) [point value]** (10-13)
- Migration of pain [1]
- Anorexia [1]
- Nausea/Vomiting [1]
- RLQ tenderness [2]
- Cough/Hopping/Percussion tenderness in RLQ [2]
- Elevation of temperature [1]
- Leukocytosis (≥10,000) [1]
- Differential WBC with left shift [1]
- The PAS is the cumulative point total from all clinical findings

**Critical Points of Evidence**

**Evidence Supports**
- Use the PAS to predict the presence of appendicitis in children ≥4 years. (10-13) — Strong recommendation, moderate quality evidence
- Utilize ultrasound (US) as the initial imaging modality in children with appendicitis. CT should be obtained only when US is equivocal or further investigation is needed in diagnosing appendicitis in children. (15,17-21) — Strong recommendation, moderate quality evidence. Remarks: CT is more accurate than US in diagnosing appendicitis in children. However, the risk of radiation exposure needs to be considered. Texas Children’s Hospital data supports US as equivalent to CT in diagnosing appendicitis in the majority of children, excluding some obese patients. (22)
- A timely diagnosis of appendicitis should be made by physicians in the ED. (23) — Strong recommendation, low quality evidence
- Laparoscopic appendectomy is the preferred surgical approach (vs. open surgery) for children with appendicitis. (24-28) — Strong recommendation, moderate quality evidence
- Postoperative pain medications should be scheduled. (29,30) — Strong recommendation, low quality evidence
- In complicated/advanced appendicitis, monotherapy should be administered for a minimum of 3 days to reduce postoperative infectious complications in children undergoing an appendectomy. (31-34) — Strong recommendation, moderate quality evidence
- An ultrasound should be used postoperatively to determine whether or not an abscess is present in patients with complicated appendicitis. (35) — Strong recommendation, very low quality evidence
- A localized fluid collection should be drained if the collection has an estimated size of >4cm. (36-38) — Strong recommendation, very low quality evidence
- Discontinue antibiotic therapy at discharge once clinical discharge criteria are met (afebrile, tolerating regular diet, pain controlled with oral pain medications, ambulating, and benign abdominal physical exam with no tenderness or mass). (39-44) — Strong recommendation, low quality evidence

**Evidence Against**
- Do not withhold analgesia. Withholding analgesia does not aid in the diagnosis of appendicitis. (45-50) — Strong recommendation, high quality evidence
- Do not routinely obtain perioperative cultures. (51-56) — Strong recommendation, low quality evidence
- **Remarks:** All children with drained abscesses should have anaerobic and aerobic cultures obtained from abscess fluid.
- Do not routinely administer postoperative antibiotics to children with simple appendicitis. (57,58) — Strong recommendation, moderate quality evidence
- Do not use biomarker testing to predict further antibiotic therapy in pediatric patients with complicated appendicitis with ongoing signs and symptoms post-appendectomy. (30,44,59-63) — Strong recommendation, low quality evidence

**Evidence Lacking/Inconclusive**
- Children with complicated appendicitis and a penicillin allergy should be treated with IV ciprofloxacin and metronidazole; if they meet clinical but not laboratory discharge criteria, transition to PO ciprofloxacin and metronidazole for discharge to home. — Consensus recommendation
- Patients with complicated appendicitis who do not achieve discharge criteria should be imaged at 6-7 days only if clinical suspicion for abscess. — Consensus recommendation
- In patients with complicated appendicitis who require percutaneous drainage, keep the drain in place until output is <10 - 20 mL/day and the patient is clinically improving. Routinely flush the drain with 10mL of saline per day. Consider TPA in complex collections with minimal output from a correctly placed drainage catheter after discussion between clinical teams, including surgery and IR. The amount of TPA should be determined based on size and location of collection. — Consensus recommendation
- There is insufficient evidence for the following topics: non-operative management of appendicitis, (16,64-68) interval appendectomies for abscesses or phlegmons. (69-71)

*NOTE: The references cited represent the entire body of evidence reviewed to make each recommendation.*
Classification of Appendicitis
- Appendicitis is classified based upon intraoperative findings.
- Complicated appendicitis includes the presence of an ileus, diffuse peritonitis, fibrino-purulent fluid in location other than RLQ, or a visible hole in appendix.
- Gangrenous appendicitis is treated as simple appendicitis.

Surgical Approach (24,25)
- Laparoscopic approach is preferred; perform open appendectomies only for: (1) very small children in whom insufflation is not technically feasible, (2) cases of neglected perforated appendicitis with large abscesses, or (3) as a conversion from laparoscopy due to inappropriate visualization, extreme inflammation.

Perioperative Cultures (45-48)
- Intraoperative cultures should not be routinely be obtained.
- All children with drained abscesses should have anaerobic and aerobic cultures obtained from abscess fluid.

Pain Management (29,30,39-44,73-75)
- Administer analgesia to promote comfort.
- Withholding analgesia does not improve diagnostic accuracy.
- Schedule postoperative pain medication.

Antibiotics (31-34,40,44,59-63,76,77)
- Administer piperacillin/tazobactam (Zosyn®) monotherapy as soon as possible once the diagnosis is confirmed.
- Administer a second dose of monotherapy prior to making the surgical incision if it has been ≥2 hours since the last dose.
- Continue monotherapy for a minimum of 3 days in children with complicated appendicitis.
- If the patient has a penicillin allergy or the intraoperative culture shows *Pseudomonas*, use/change to PO ciprofloxacin and metronidazole.
- Discontinue antibiotic therapy at discharge once clinical discharge criteria are met (afebrile, tolerating regular diet, pain controlled with oral pain medications, ambulating, and benign abdominal physical exam with no tenderness and mass).
- Postoperative antibiotics are unnecessary in children with simple appendicitis.

Postoperative Imaging and Procedures – Complicated Appendicitis (26)
- Perform US at 6-7-days postoperatively to rule out abscess in patients with complicated appendicitis, if clinical suspicion for abscess.
- Drain localized fluid collection if estimated size ≥4 cm.

Discharge Criteria
- Afebrile
- Tolerating regular diet
- Pain controlled with oral pain medications
- Benign abdominal physical exam (no tenderness/mass)
- Ambulating

Consults/Referrals
- Consult Surgery for a PAS ≥8 or proven appendicitis.
- Consult IR for abscess confirmation.
- Consult Infectious Disease if complicated intra-abdominal abscess(es), recurrent abscess or multiple drains, prolonged length of stay.
- Request to see Child Life for coping techniques, procedural teaching, and psychosocial support.
- Request to see Nutritional Support for dietary modifications related to surgery and healing.

Measures
Process
- Perforation rates noting ED admit time, time at which diagnosis was made, and time of surgery
- Appropriateness of antibiotic therapy
- Diagnostic accuracy (sensitivity, specificity) of US and CT
- BMI of children who received CT
- Indication for ordering CT
- Frequency of lab orders for diagnostic purposes where the PAS is 5-7
- Frequency of radiologic studies in patients where the PAS is 1-4 or ≥8
- Percentage of CT scans to rule out abscess in patients with complicated appendicitis
- Percentage of CT scans to rule out abscess at 6 days or 7 days

Outcome
- Return visit within 24 hours of previous ED visit
- Length of stay (ED, Inpatient and Special Care)
- Readmission rate for postoperative complications within 30 days
- Complications (negative appendectomy, abscess, and wound infection)
- Percentage of patients experiencing any moderate or severe pain in the first 3 postoperative days
- Percentage of patients experiencing >1 episode of moderate or severe pain on any of the first 3 postoperative days
TCH Evidence-Based Outcomes Center
Acute Appendicitis/Appendectomy Management Algorithm

**Classification of Appendicitis**: A diagnosis of acute appendicitis requires a combination of clinical findings and imaging. Appendicitis can be classified as uncomplicated or complicated.

**Acute Appendicitis**: This includes cases where the appendix is inflamed but not necrotic or perforated.

**Complicated Appendicitis**: This includes cases where the appendix is necrotic or perforated, or has developed complications such as abscess or phlegmon.

**Gangrenous Appendicitis**: This is a specific type of complicated appendicitis where the appendix is gangrenous due to ischemia.

**Abscess or Phlegmon**:
- No visible hole
- No diffuse peritonitis
- No fibrino-purulent fluid in location other than RLQ

**PAS (Pediatric Appendicitis Score)**: This score is used to guide management decisions. It is calculated by assigning points for different clinical findings:

- **PAS 0**: Low suspicion of appendicitis
- **PAS 5.7**: Equivocal suspicion of appendicitis
- **PAS 8.6**: High suspicion of appendicitis

**Discharge Criteria (DC)**:
- Abnormality 24 hours (IO.4-9)
- Testing regular diet
- Pain controlled with oral pain medications
- Antibiotics
- Normal abdominal physical exam (no tenderness/mass)
- Discharge when criteria met

**Surgical Management**:

- **Appendectomy**
- Order analgesia as warranted
- Order US examination

- **US equivocal**
  - Image positive for abscess/phlegmon?
  - Yes: Consult Surgery
  - No: Admit
  - Begin empiric therapy with piperacillin/tazobactam
  - Consult Infectious Disease
  - Consider IR drainage of abscess

- **US positive**
  - Image positive for abscess/phlegmon?
  - Yes: Consult Surgery
    - Order CT
    - Obtain surgery consult
    - Report to ordering CT
  - No: Admit
  - Begin empiric therapy with piperacillin/tazobactam
  - Consult Infectious Disease
  - Consider IR drainage of abscess

**Advanced or Complicated Appendicitis**

- Begin empiric therapy with piperacillin/tazobactam (at minimum dosing to allow re-dose if needed)
- If 48 hours antibiotics dose: Re-dose with full minimum dosing
- Request to see Child Life
- Perform appendectomy

**Discharge Criteria Met?**

- Yes: Discharge home
- No: Reassess discharge criteria after 48 hours


Clinical Standards Preparation
This clinical standard was prepared by the Evidence-Based Outcomes Center (EBOC) team in collaboration with content experts at Texas Children’s Hospital. Development of this clinical standard supports the TCH Quality and Patient Safety Program initiative to promote clinical standards and outcomes that build a culture of quality and safety within the organization.

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Development Process
This clinical standard was developed using the process outlined in the EBOC Manual. The literature appraisal documents the following steps:

1. Review Preparation
   - PICO questions established
   - Evidence search confirmed with content experts

2. Review of Existing External Guidelines
   - Cincinnati Children’s Hospital Emergency Appendectomy, BMJ

3. Literature Review of Relevant Evidence
   - Searched: Searched: Cochrane, PubMed, CINHAL, Google Scholar, ProQuest, and SumSearch

4. Critically Analyze the Evidence
   - 9 systematic reviews, 21 randomized controlled trials, and 39 nonrandomized studies

5. Summarize the Evidence
   - Materials used in the development of the clinical standard, literature appraisal, and any order sets are maintained in an appendicitis/appendectomy evidence-based review manual within EBOC.

Evaluating the Quality of the Evidence
Published clinical guidelines were evaluated for this review using the AGREE II criteria. The summary of these guidelines are included in the literature appraisal. AGREE II criteria evaluate Guideline Scope and Purpose, Stakeholder Involvement, Rigor of Development, Clarity and Presentation, Applicability, and Editorial Independence using a 4-point Likert scale. The higher the score, the more comprehensive the guideline.

This clinical standard specifically summarizes the evidence in support of or against specific interventions and identifies where evidence is lacking/inconclusive. The following categories describe how research findings provide support for treatment interventions.

- “Evidence Supports” provides evidence to support an intervention
- “Evidence Against” provides evidence against an intervention
- “Evidence Lacking/Inconclusive” indicates there is insufficient evidence to support or refute an intervention and no conclusion can be drawn from the evidence.

The GRADE criteria were utilized to evaluate the body of evidence used to make practice recommendations. The table below defines how the quality of the evidence is rated and how a strong versus weak recommendation is established. The literature appraisal reflects the critical points of evidence.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRONG</td>
<td>Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies</td>
</tr>
<tr>
<td>WEAK</td>
<td>Evidence from RCTs with important limitations (e.g., inconsistent results, methodological flaws, indirect evidence, or imprecise results) or unusually strong evidence from unbiased observational studies</td>
</tr>
<tr>
<td>LOW</td>
<td>Evidence for at least 1 critical outcome from observational studies, RCTs with serious flaws or indirect evidence</td>
</tr>
<tr>
<td>VERY LOW</td>
<td>Evidence for at least 1 critical outcome from unsystematic clinical observations or very indirect evidence</td>
</tr>
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</table>

Recommendations
Practice recommendations were directed by the existing evidence and consensus amongst the content experts. Patient and family preferences were included when possible. The Content Expert Team and EBOC team remain aware of the controversies regarding appendicitis/appendectomies in children. When evidence is lacking, options in care are provided in the clinical standard and the accompanying order sets (if applicable).

Approval Process
Clinical standards are reviewed and approved by hospital committees as deemed appropriate for its intended use. Clinical standards are reviewed as necessary within EBOC at Texas Children’s Hospital. Content Expert Teams are involved with every review and update.

Disclaimer
Practice recommendations are based upon the evidence available at the time the clinical standard was developed. Clinical standards (guidelines, summaries, or pathways) do not set out the standard of care and are not intended to be used to dictate a course of care. Each physician/practitioner must use his or her independent judgment in the management of any specific patient and is responsible, in consultation with the patient and/or the patient’s family, to make the ultimate judgment regarding care.
## Version History

<table>
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<th>Date</th>
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<td>Jan 2012</td>
<td>Originally completed</td>
</tr>
<tr>
<td>Apr 2015</td>
<td>Addendum for postoperative management of complicated appendicitis; remainder of guideline reaffirmed</td>
</tr>
<tr>
<td>Mar 2018</td>
<td>Removed TPN recommendation and clarified algorithm wording for complicated appendicitis</td>
</tr>
<tr>
<td>July 2018</td>
<td>Added two PICO questions, updated algorithm, archived original question</td>
</tr>
<tr>
<td>Jan 2019</td>
<td>Revised the ‘Vital Sign Changes of Sepsis’ table</td>
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<tr>
<td>Feb 2023</td>
<td>Guideline Update</td>
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